STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155255		A. BUII	LDING	nstruction 01	(X3) DATE : COMPL 01/05/2	ETED	
		100200	B. WIN			01/03/2	U 12
	ROVIDER OR SUPPLIER			3420 E	DDRESS, CITY, STATE, ZIP CODE STATE BLVD VAYNE, IN46805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	REGUESTION OR	ESC IDENTIFICATION ORGANITION		1110			DATE
K0000	A Life Safety Coand State Licenconducted by the Department of accordance with Survey Date: Of Facility Number Provider Number Alm Number: If Surveyor: Amy Code Specialist At this Life Safe Woodview Health Cound not in concequirements of Medicare/	ode Recertification sure Survey was he Indiana State Health in h 42 CFR 483.70(a). 1/05/12 r: 000158 er: 155255 100291490 Kelley, Life Safety ety Code survey, thcare Inc. was ompliance with for Participation in caid, 42 CFR 0(a), Life Safety he 2000 edition of re Protection FPA) 101, Life Safety apter 19, Existing cupancies and 410 facility was be of Type V (111)	K	0000	This plan of correction is to s as Woodview Healthcare's allegation of compliance	erve	
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	.	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HDP421

Facility ID:

000158

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155255			LDING	01	(X3) DATE (COMPL 01/05/20	ETED
	ROVIDER OR SUPPLIER		S. WIN	3420 E S	DDRESS, CITY, STATE, ZIP CODE STATE BLVD /AYNE, IN46805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	alarm system we detection in the open to the corroom on the Re The facility has and had a cens time of this sur Quality Review by F Code Specialist-Med The facility was compliance wit aforementioned	e corridors, areas ridors and resident chabilitation Hall. a capacity of 128 us of 103 at the vey. Robert Booher, Life Safety dical Surveyor on 01/11/12.					
K0017 SS=E	walls constructed or resistance rating. partitions are only passage of smoke buildings, walls proceiling. (Corridor or underside of ceilin permitted by Code stations, waiting an activity spaces maunder certain concount of the control of the contr	with at least ½ hour fire In sprinklered buildings, required to resist the In non-sprinklered perly extend above the walls may terminate at the gs where specifically Charting and clerical reas, dining rooms, and y be open to the corridor litions specified in the Code. separated from corridors valls if the gift shop is fully 3.6.1, 19.3.6.2.1, 19.3.6.5					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255		LDING	01	(X3) DATE COMPI 01/05/2	LETED
NAME OF PROVIDER OR SUPPLIER WOODVIEW HEALTHCARE INC				3420 E	ADDRESS, CITY, STATE, ZIP CODE STATE BLVD WAYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 RIATE	(X5) COMPLETION DATE
	ensure 1 of 1 f and 1 of 1 Soc were separated by a partition of the passage of in a sprinklere an Exception. Exception # 6, patient sleeping rooms, and had be open to the unlimited in an space and correspace opens of smoke compand by an electrical automatic smooth system, and (b) protected by a sprinklers, and arranged not to required exits. practice could near the main main dining rooth	Facility failed to Reception offices ial Service offices if from the corridors capable of resisting smoke as required d building, or met LSC 19-3.6.1, Spaces other than g rooms, treatment zardous areas may corridor and ea provided: (a) The idors which the into in the same tment are protected fly supervised ly supervised le detection Each space is n automatic f(c) The space is o obstruct access to This deficient affect any residents entrance and in the om. de:	K	0017	It is the policy practice of Woodview Healthcare, Inc. in accordance with NFPA 1 Safety Code standards. No residents were affected by potentially affected by the deficient practice. The Recand Social Service Offices, have sliding glass windows both offices were fully sprinat the time of the inspection 1/27/12, Shambaugh & Soc Contractors installed into the Reception and Social Serv Office, "electrically supervisautomatic smoke detectors (Attachment G). Both Smood Detectors have also had sensitivity testing performe (Attachment H) as required offices have been inspecte no other offices were obseinave sliding glass windows Director of Operations will smoke Detector Sensitivity Testing Records annually the ensure facility is in complia with testing requirements. Quality Assurance committionersee Director of operation and annual documentation compliance. Date of Completion: 2/4/2012	01 Life or or seption did s, but sklered n. On ne seed ke d All d and eved to s. The monitor once The ee will ons,	02/04/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL B. WING	LDING	NSTRUCTION 01	(X3) DATE S COMPL 01/05/20	ETED	
NAME OF P	ROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE		
WOODVI	EW HEALTHCARE	INC			STATE BLVD VAYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	Ē	(X5) COMPLETION DATE
	Reception office Service office he windows in the There was a on between the part both windows. Exception # 6, the LSC Section met because the and the Social Supervised autodetection systems	e and the Social and sliding glass corridor walls. The fourth inch gap in the fourth inch gap in the fourth energy and electrically comatic smoke the Maintenance of the Maintenance of the Maintenance of the Service of the Maintenance of the Maintenance					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	(X2) MI A. BUII B. WIN	LDING	ONSTRUCTION (X3) DATE SUR 01 COMPLETE 01/05/2012		ETED
	PROVIDER OR SUPPLIER		•	3420 E S	DDRESS, CITY, STATE, ZIP CODE STATE BLVD VAYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0029 SS=E	fire-rated doors) of extinguishing system and/or 19.3.5.4 provided in the approve extinguishing system are separated from resisting partitions self-closing and no protective plates the from the bottom of 19.3.2.1 Based on observing interview, the frequirements of a could affect all main hall dining the findings included affect all main the findings included affec	em option is used, the areas of other spaces by smoke and doors. Doors are con-rated or field-applied that do not exceed 48 inches if the door are permitted. Evation and acility failed to coll down fire doors in the kitchen wall, ea, would self close of the fire alarm eficient practice residents in the groom.	K	0029	It is the policy practice of Woodview Healthcare, Inc. to in accordance with NFPA 10 Safety Code standards. No residents were affected by on potentially affected by the deficient practice. Two padlo have been installed to the rol window. The Window has be locked in the closed position will no longer be utilized and/opened. The Director of Operations and Maintenance Director, will be only personn hold a key to the Rolling Win Dietary will not have access open window. All Dietary Stahave been educated on Life Safety Requirements that Window must be closed (See Attachment D). The Director Operations will oversee staff compliance and ensure the window is in the closed positional locked. The Quality Assurance Committee will oversee staff compliance, monthly, and ensure window longer used (Quality Assurance Checklist Attachment E). Da	1 Life cocks lling een and for elel to dow. to aff er of for is no nce	02/04/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/01/2012 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	(X2) MULT A. BUILDI B. WING		01	(X3) DATE S COMPLI 01/05/20	LETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3420 E STATE BLVD FORT WAYNE, IN46805					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE	
	wall between the the kitchen. The protected by a with a fusible light interview with Managery Supervisor at the observation, the	rolling fire door nk. Based on Maintenance			Completion: 2/4/2012			
K0052 SS=E	installed, tested, a accordance with N Code and NFPA 7 approved maintencomplying with app NFPA 70 and 72. Based on recordinterview, the fensure 1 of 1 fi was maintained the applicable of NFPA 72, Natio	FPA 70 National Electrical 2. The system has an ance and testing program policable requirements of 9.6.1.4 dreview and acility failed to re alarm systems in accordance with requirements of all Fire Alarm 4, 7-3.2 requires	K005	52	It is the policy practice of Woodview Healthcare, Inc. to in accordance with NFPA 101 Safety Code standards. No residents were affected by or potentially affected by the deficient practice. Shambaugand Sons provides smoke detector sensitivity testing according to NFPA 101 Life	1 Life	02/04/2012	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HDP421 Facility ID:

000158

If continuation sheet

Page 6 of 9

NAME OF PROVIDER OR SUPPLIER WOODVIEW HEALTHCARE INC SIBMARY STATEMENT OF DEPICIENCIES TAG SIBLIT ANDRESS, CITY, STATE, ZIP CODE 3420 E STATE BLVD FORT WAYNE, INABBOS ID SOMMARY STATEMENT OF DEPICIENCIES TAG SERVING COMPLETON COMPLETON DATE SERVING COMPLETON COMPLETON DATE SERVING COMPLETON (XS) SAFEL CODE SAFE STATE BLVD FORT WAYNE, INABBOS ID SOMMARY STATEMENT OF DEPICIENCIES ID SOMMARY STATEMENT OF DEPICIENCIES TAG SERVING COMPLETON DATE (XS) (XS) COMPLETON DATE SERVING COMPLETON DATE SERVING COMPLETON DATE (XS) SAFELY CODE STATE BLVD COMPLETON DATE SERVING COMPLETON DATE (XS) COMPLETON DATE SERVING COMPLETON DATE (XS) COMPLETON DATE SERVING COMPLETON DATE (XS) COMPLETON DATE SERVING COMPLETON DATE SERVING COMPLETON DATE (XS) SAFELY CODE STATE BLVD COMPLETON DATE SERVING COMPLETON DATE (XS) (XS) (XS) (XS) COMPLETON DATE SERVING COMPLETON COMPLETON COMPLETON COMPLETON DATE SERVING COMPLETON COMPLET	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION O1			(X3) DATE SURVEY COMPLETED		
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WOODVIEW HEALTHCARE INC WOODVIEW HEALTHCARE INC SIMMARY STATIMENT OF PERCINCES RECULATORY OR LSC IDENTIFYING INFORMATION) Chapter 7 or more often if required by the authority having jurisdiction. Table 7–3.2 "Heating apply. Table 7–3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect any number of residents, staff and visitors. Findings include: Based on review of the Shambaugh and Sons smoke detector record titled "Initialing Device Test Report" with the Administrator, Director of Operations and the Maintenance Supervisor on 01/05/12 at 2:35 p.m., of the fifty three smoke detectors in the facility only seventeen received a smoke detector sensitivity test. Based on an interview with the Administrator at the time of record review, no other documentation was available for review. 3 1–19(h) SIMMARY STATIMENT OF PERCIENCES PRETY MAYNE, INA6805 (X5) PRETX TAG Salety Code Standard. On 1/13/2012, Shambaugh and Sons reviewed documentation, the inspector of eresived documentation, the inspector of celectors receiving sensitivity testing was only required tested ensured the inspector section of Shambaugh and Sons indicated sensitivity testing was only required testing every 5 years. There were no reports of malfunctioning smoke detectors. Smoke Detector Sensitivity Testing was completed on all smoke detectors. Smoke Detector Sensitivity Testing was completed on all smoke detectors. See (See (Attachment B). The facility has a total of 53. All Smoke Detector sensitivity testing universelved on all smoke detectors. Shambaugh and Sons will continue to complete Smoke Detector Sensitivity Testing requirements. Shambaugh and Sons midle Director of Operati	100200			B. WIN		A DDDDGG GUTY GTATE TID GODE	01/03/2	012
MOODVIEW HEALTHCARE INC FORT WAYNE, IN48805	NAME OF I	PROVIDER OR SUPPLIEF	₹					
PREFIX TAG REGILATORY OR LSC IDENTIFYING REFORMATION) accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7–3.2 shall apply. Table 7–3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect any number of residents, staff and visitors. Findings include: Based on review of the Shambaugh and Sons smoke detector record titled "initialing Device Test Report" with the Administrator, Director of Operations and the Maintenance Supervisor on 01/05/12 at 2:35 p.m., of the fifty three smoke detectors in the facility only seventeen received a smoke detector sensitivity test. Based on an interview with the Administrator at the time of record review, no other documentation was available for review. British the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7–3.2 shall saccording to Safety Code Standard. On 1/13/2012, Shambaugh and Sons reviewed documentation, the inspector clied regarding only 17 of 56 smoke detectors receiving sensitivity testing was only required documentation, the inspector clied regarding only 17 of 56 smoke detectors according to the inspector clied regarding only 17 of 56 smoke detectors according to the inspector clied regarding only 17 of 56 smoke detectors according to the inspector clied regarding only 17 of 56 smoke detectors according to the inspector clied regarding only 17 of 56 smoke detectors according to the inspector clied regarding only 17 of 56 smoke detectors according to the inspector clied regarding only 17 of 56 smoke detectors according to the inspector clied regarding only 17 of 56 smoke detectors according to the inspector clied regarding only 17 of 56 smoke detectors according to the inspector clied regarding only 17 of 56 smoke detectors. The remaining smoke detectors sensitivity testing required on the 17 inspector of the inspector of the inspector of the insp	WOODV	IEW HEALTHCARE	EINC					
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Chapter 7 or more often if required by the authority having jurisdiction. Table 7–3.2 shall apply. Table 7–3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect any number of residents, staff and visitors. Findings include: Based on review of the Shambaugh and Sons indicated sensitivity testing was only required on the 17 smoke detectors only required on the 17 smoke detectors only required testing every 5 years. There were no reports of malfunctioning smoke detectors. Smoke Detector Sensitivity testing was not predicted on all smoke detectors. Smoke Detectors Sensitivity testing was not predicted on all smoke detectors. Smoke Detectors Sensitivity tables in the facility only seventeen received a smoke detector sensitivity test. Based on an interview with the Administrator at the time of record review, no other documentation was available for review. Chapter 7 or more often if reviewed documentation, the inspector detectors receiving sensitivity testing sensitivity testing and Sons indicated sensitivity testing was only required neth 17 smoke detectors and the replaced smoke detectors only required testing every 5 years. There were no reports of malfunctioning smoke detectors. Smoke Detector Sensitivity testing was completed on all smoke detectors. Smoke Detectors Sensitivity Testing New 2011 (2012) (2012). On 1/20/2012, Smoke Detectors will required until 2/2012. On 1/20/2012, Smoke Detectors will required the 2/2012. On 1/20/2012, Smoke Detectors will required the 2/2012. On 1/20/2012, Smoke Detectors will required the 1/2012 (2012). On 1/20/2012, Smoke Detectors will required the 1/2012 (2012). On 1/20/2012, Smoke Detectors will required the 1/2012 (2012). On 1/20/2012, Smoke Detectors will required the 1/2012 (2012). On 1/20/2012, Smoke Detectors will required the 1/2012 (2012). On 1/20/2012, Smoke Detector Sensitivity Testing New 2012 (2012). Smoke Detector Sensitivity Testing New 2012 (201	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155255		A. BUII	LDING	01	COMPL 01/05/2	ETED		
NAME OF F	PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3420 E STATE BLVD					
WOODV	EW HEALTHCARE	INC			VAYNE, IN46805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
K0056 SS=E	installed in accord. Standard for the Ir Systems, to provide portions of the build properly maintaine 25, Standard for the Maintenance of W Systems. It is fully reliable, adequate system. Required equipped with wat switches, which are the building fire also Based on observinterview, the form of 2 building accordance with Standard for Instandard for	vation and acility failed to ete automatic m was provided for canopies in h NFPA 13, stallation of ms, to provide age for all portions NFPA 13-1999 15-13.8.1 requires be installed under or canopies in width. This ce could affect any ated through the in the event of an	K	0056	It is the policy practice of Woodvie Healthcare, Inc. to be in accordance with NFPA 101 Life Safety Code standards. No residents were affected by or potentially affected by the deficient practice. A sprinkler is to be installed beneat the front porch canopy (See Attachment C). At this time, the installation is scheduled for 1/26/2012. There are no other canopy/overhang(s) in the building that are without an automatic sprinkler. While at this time there are no plans to add any additional overhangs, in the event this should occur, "The Director of Operations shall immediately inform the Administrator and the Administrate will oversee facility compliance an ensure the area is sprinklered. Date of Completion: 2/4/2012	ee nt th	02/04/2012	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HDP421 Facility ID:

000158

If continuation sheet

Page 8 of 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	LDING	NSTRUCTION 01	(X3) DATE COMPI 01/05/2	LETED
NAME OF PROVIDER OR SUPPLIER WOODVIEW HEALTHCARE INC			3420 E	DDRESS, CITY, STATE, ZIP CODE STATE BLVD VAYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	Administrator, Operations and Supervisor on C a.m., the canon main building a extends out over entrance of the exterior of the noncombustible based on an information of the time of observation of the wood. Based of interview with the Operations on a.m., the canon	I the Maintenance 01/05/12 at 11:55 by in between the and the dining room er the main building. The canopy is made of e material but terview with the ation, the roof anopy were made of on a telephone the Director of 01/11/12 at 10:34 by extends twenty he building and				